STATE OF DELAWARE - Health Care and Dependent Care Flexible Spending Accounts
ELECTION CHANGE FORM FOR PLAN YEAR 2010

Please type or print clearly – Completed form must be delivered to your Human Resources Office or Statewide Benefits Unit (fax: 302-739-8339) within 31 days of the qualified change.

Plan Year – From: To:	**Date of Event:**
Employee Name:	**Employee ID:**
Agency: **Benefits Representative Name:**	**Daytime Phone Number:**

I understand that I may change my Health Care Spending Account or Dependent Care Spending Account Election(s) if I experience a "qualified change in status" as mandated by Internal Revenue Code Regulations. I certify that the following "qualified change in status" has occurred:

❑ Marriage	❑ Birth, Adoption or placement of adoption of a child	❑ Cost Change - Dependent Care Only (provider not a relative)
❑ Divorce finalized ❑ Death - Spouse or Dependent ❑ Annulment	❑ Dependent satisfies or ceases to satisfy eligibility Explain_____	❑ Provider Change - Dependent Care Only
❑ Judgment, Decree or Court Order – Health Care Only	❑ Change in Employment Status of Employee, spouse or dependent	❑ Child turns age 13 - Dependent Care Only
❑ Gain or loss of eligibility and coverage under Medicare/Medicaid – Health Care Only	❑ Check here if change above is for spouse	❑ FMLA – Begin/End

BENEFIT ELECTION

I hereby certify that the above event has occurred and agree that this change in election has been the result of and is consistent with, the event indicated above. If a change in election is made, the new election amount will be effective for expenses incurred the first of the month following the latter of: 1) the date of the event, or 2) the date this form is signed.

❑ I elect to change my previous election in the Health Care Flexible Spending Account. My annual election for the plan year will now be $_____. I understand my pay period deductions will be modified accordingly.

❑ I elect to change my previous election in the Dependent Care Flexible Spending Account. My annual election for the plan year will now be $_____. I understand my pay period deductions will be modified accordingly.

❑ I elect to stop having my pay reduced on a pre-tax basis. I understand that this election will remain in effect throughout the remainder of the current plan year unless there is another qualified change.

EMPLOYEE SIGNATURE	DATE

RETURN THIS FORM TO STATEWIDE BENEFITS BY FAX, 302-739-8339.
PLEASE CONTACT STATEWIDE BENEFITS UNIT, AT (302) 739-8331 WITH QUESTIONS.